

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29CY	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/03/2024
NAME OF PROVIDER OR SUPPLIER COURTYARDS COMM LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 EAST WALKER STREET FULTON, MS 38843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	Initial Comments The State Agency (SA) conducted a revisit survey at the facility from 4/2/24 through 4/3/24. During the survey, the SA determined that the facility was back in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with the completion date of 3/19/24. The census at the time of the survey was 57 with a bed capacity of 66 beds.	{M 000}		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/10/24